STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

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John A. Stephen
Commissioner

Norman W. Cordell
Director

Date: January 22, 2007

To: Hospital Discharge Planners

From: Donald R. Hunter
Medicare Part D Coordinator

Re: Home Infusion Therapy

The Medicare Part D Program has now been in operation for a full calendar year. During that time there have been a number of implementation challenges, including the provision of home infusion therapy. All have been successfully dealt with on a team basis thereby ensuring that our dual eligible clients (on NH Medicaid and Medicare) received the high quality, cost effective services that they required in a timely and appropriate manner.

Recognizing these challenges, the State of New Hampshire extended the use of temporary supplemental pharmacy assistance funds (referred to as the "override" program) to provide for the home infusion therapy needs of dual eligible beneficiaries for a limited time when situations warranted this action.

According to CMS guidance issued in March of 2006:

- "Medicare Part D requires coverage of home infusion drugs that are not currently covered under Parts A & B of Medicare. Although the Medicare Part D benefit does not cover equipment, supplies, and professional services associated with home infusion therapy, it does cover the ingredient costs and dispensing fees associated with infused covered Part D drugs."
- "In addition, the Part D plan's contracted pharmacy is expected to deliver home infused drugs in a form that can be administered in a clinically appropriate fashion." Part D plans must have "home infusion networks and contracted pharmacies capable of providing infusible Part D drugs for both short-term acute care (e.g., IV antibiotic) and long-term chronic care (e.g., alpha' protease inhibitor)."
- Plans must also "ensure enrollees have adequate access to medically necessary home infusion therapies when needed" as well as making sure that their customer and provider service lines provide "clear directions on how to contact an in-network pharmacy for appropriate coverage of Part D home infused drugs."

A copy of this CMS guidance is included for your reference. This guidance includes a table outlining how Medicare pays for home infusion therapy and a decision tree addressing the coordination of home infusion therapy. A copy of a letter to State Medicaid Directors is also included. This letter reinforces the CMS home infusion guidance.

It is the Department's understanding that Part D plans are capable of meeting all requirements and are providing the home infusion drugs required by the enrolled clients. At the same time it is our understanding that equipment, supplies and professional services required to administer the drugs are being covered by appropriate sources.

It is the Department's current position that all aspects of home infusion should be adequately covered as provided under CMS requirements and guidelines and that the continued use of the override program will no longer be appropriate (for dates of service) on or after February 1, 2007. Accordingly, the override will be discontinued on that date. Based on the availability of service coverage that is expected on the part of the Part D plans, the termination of the use of the override should have no negative impact on the provision of home infusion services.

The Department is taking several additional steps to assist your efforts to serve dual eligible patients needing home infusion therapy as part of their discharge plan. Included with this letter is an explanation of steps to report and resolve Part D complaints and problems. Depending on the urgency of the situation, plans have strict timelines and requirements for responding to complaints. Also included is a list of the customer service phone numbers for all Part D plans operating in NH. We have requested a list of the home infusion providers in each Part D plan's NH network along with home infusion contacts for each Part D plan. This information will be passed along as soon as we obtain it.

You may feel free to direct any questions on this matter to me at 603-271-5255, or email donald.r.hunter@dhhs.state.nh.us.

Your cooperation and assistance in this matter is appreciated.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

**CENTER FOR BENEFICIARY CHOICES**

**March 10, 2006**

**Memorandum To:** All Part D Sponsors

**Subject:** Home Infusion Therapy

**From:** Gary Bailey, Deputy Director, Center for Beneficiary Choices

As we move into the third month of implementing the Medicare Drug Benefit, we want to clarify for prescription drug plan sponsors the Part D benefit for home infusion therapy as we are hearing numerous complaints in this area. We believe that your review of this letter and attachments will assist us in making this benefit more effective for your members.

As you are aware, we require coverage of home infusion drugs under Part D that are not currently covered under Parts A and B of Medicare. Although the Medicare Part D benefit does not cover equipment, supplies, and professional services associated with home infusion therapy, it does cover the ingredient costs and dispensing fees associated with infused covered Part D drugs. Please refer to Attachment I to this letter which describes the payment obligations under Medicare for home infusion therapy.

Clear Directions to Access Home Infusion Pharmacy

We have been hearing complaints about the inability of beneficiaries and their providers to identify and access in-network systems capable of delivering home infusion drugs covered under Medicare Part D. We remind plan sponsors that they need to have in place through their customer and provider service lines clear directions on how to contact an in-network pharmacy for appropriate coverage of Part D home infused drugs.

Home Infusion Drugs Must be Provided In a Usable Form

We have been hearing complaints about beneficiaries receiving drugs to be used for their home infusion therapy in an unmixed, unusable form. It is important to emphasize that, while we do not expect the Part D plans to provide or pay for supplies, equipment, or the professional services needed for home infusion therapy, we do expect the plan sponsor's contracted pharmacy to deliver home infused drugs in a form that can be administered in a clinically appropriate fashion.

In addition, home infusion networks must have contracted pharmacies capable of providing infusible Part D drugs for both short term acute care (e.g. IV antibiotics) and long term chronic care (e.g. alpha[1] protease inhibitor) therapies. While the same network pharmacy does not

necessarily need to be capable of providing the full range of home infusion Part D drugs, the home infusion network, in aggregate, must have a sufficient number of pharmacies capable of providing the full range of home infusion Part D drugs to ensure enrollees have adequate access to medically necessary home infusion therapies when needed.

Assurances that Ancillary Services Will be Provided

Generally, facility discharge planners, in collaboration with a patient's physician, are responsible for ensuring that the components needed to safely administer a drug at home are present upon a patient's discharge. However, we also expect the Part D plan's in-network contracted pharmacy vendors -- particularly those that do not supply the necessary ancillary services (which are not a Medicare Part D benefit) -- to receive assurances that another entity can arrange for the provision of these services, such as a home health agency. In other words, Part D plans must require their contracted network pharmacies that deliver home infusion drugs to ensure that the professional services and ancillary supplies are in place before dispensing home infusion drugs. We would consider this action of obtaining assurances a minimum quality assurance requirement on Part D plans under 423.153(c). Please refer to Attachment II to this letter which describes the overall decision tree with respect to the coordination of home infusion therapy.

Time Sensitive Nature of Home Infusion Therapy

Home infusion therapy may serve as a vehicle to promote early hospital discharge. We understand that there have been unexpected delays in the approval of off-formulary requests for infusion drugs. This has resulted in some beneficiaries remaining in an inpatient setting before the home infusion therapy can be initiated while an exceptions request is submitted and resolved. Because the need for home infusion therapy is often of an urgent nature, physicians dealing with home infusion therapy situations may determine that an expedited coverage determination or redetermination is necessary for their patients and communicate this information to the Part D plans. Plan sponsors should resolve these requests as quickly as possible.

Thank you for your help in ensuring that Part D enrollees have timely access to medically necessary home infusion therapy.

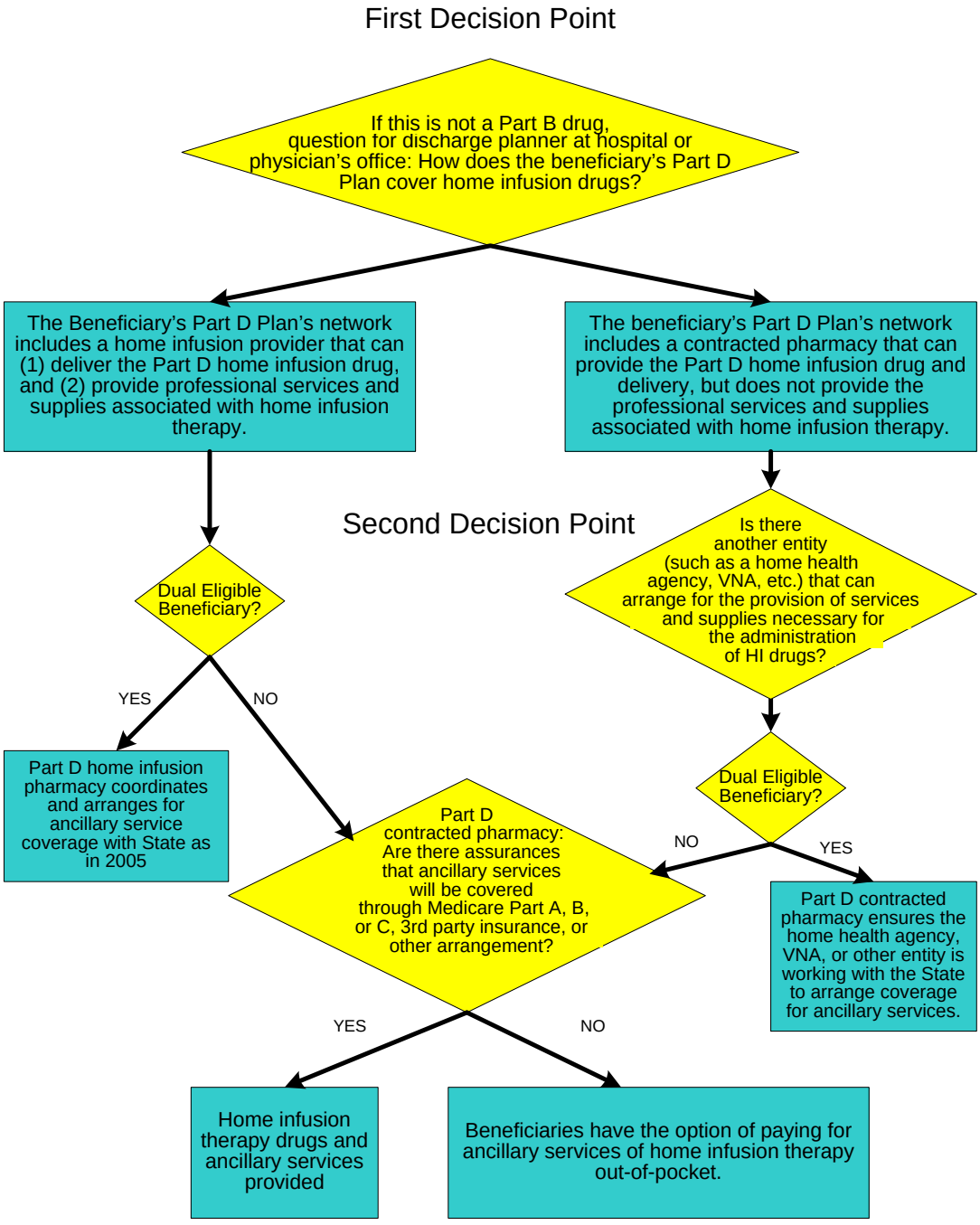
Attachment I

# Payment of Home Infusion Therapy for Medicare Beneficiaries

| | Part A Home Health | Part B DME Benefit | Part C Medicare Advantage | Part D Prescription Drug Plan | State Medicaid Program | Other Payer Coverage |
|---|---|---|---|---|---|---|
| **Requirement** | Homebound and in need of part-time or intermittent skilled nursing or therapy services, if such services are reasonable and necessary to the treatment of the illness or injury. | If medically necessary for the drug to be administered through an infusion pump. | Coverage of at least Part A/B services. Coordinated care plans may include additional coverage and mechanisms to control utilization. | Drugs that are not currently covered under Parts A and B of Medicare, or otherwise excluded under Part D. | Provided that coverage is not available through Parts A, B, C, or D of Medicare, Medicaid home health benefit may cover services, equipment and supplies necessary to administer home infusion drugs. | Varies, but generally like Part C |
| **Professional Fees** | Yes | No | Yes | No | Yes – May be billed separately or as part of bundled rate. | Varies, but generally like Part C |
| **Equipment and Supplies** | Sometimes - Home Health Therapy responsible for providing hydration fluid and IV supplies if infusion is provided via gravity feed method | Yes – Supplies are billed separately by a DME vendor to appropriate DME Regional Carrier | Yes – Included in per diem payment (generally bundled) | No – Cost of supplies, equipment, and professional fees must be covered via Medicare Parts A or B, Medicare Advantage Plan, Medicaid, other insurance, or out-of-pocket | Yes – May be billed separately or as part of bundled rate | Varies, but generally like Part C |
| **Drug Ingredient and Dispensing Fee** | No – Drugs and biologicals are specifically excluded from the Part A home health benefit | Part B pays the drug costs as a part of the DME benefit but there is no separate dispensing fee paid | If covered under Part B, yes.<br>If not covered under Part B, must be covered under Part D in a MA-PD plan. | Yes | No – Unless drugs are included in bundled rate, which does not trigger Medicaid FFP exclusion | Varies, but generally like Part C |

Attachment II

# Home Infusion Coordination Decision Tree



# 2007 - New Hampshire Medicare Part D Stand-Alone Prescription Drug Plans

| Company | Plan (and ID Numbers) | Enrollment Phone Number | Member Services Phone Number |
|---|---|---|---|
| Aetna Medicare | Aetna Medicare Rx Essentials (S5810-035) | 1-800-445-1796 | 1-877-238-6211 |
| | Aetna Medicare Rx Plus (S5810-137) | 1-800-445-1796 | 1-877-238-6211 |
| | Aetna Medicare Rx Premier (S5810-171) | 1-800-445-1796 | 1-877-238-6211 |
| Anthem Blue Cross and Blue Shield | Blue MedicareRx Value (S5596-046) | 1-866-244-1241 | 1-866-755-2776 |
| | Blue MedicareRx Value Plus (S5596-001) | 1-866-244-1241 | 1-866-755-2776 |
| | Blue MedicareRx Premier (S5596-003) | 1-866-244-1241 | 1-866-755-2776 |
| CIGNA HealthCare | CIGNATURE Rx Value Plan (S5617-003) | 1-800-735-1459 | 1-800-222-6700 |
| | CIGNATURE Rx Plus Plan (S5617-005) | 1-800-735-1459 | 1-800-222-6700 |
| | CIGNATURE Rx Complete Plan (S5617-171) | 1-800-735-1459 | 1-800-222-6700 |
| Coventry AdvantraRx | AdvantraRx Value (S5674-002) | 1-800-882-3822 | 1-866-823-5178 |
| | AdvantraRx Premier (S5674-003) | 1-800-882-3822 | 1-866-823-5178 |
| | AdvantraRx Premier Plus (S5674-005) | 1-800-882-3822 | 1-866-823-5178 |
| EnvisionRx Plus | EnvisionRxPlus Standard (S7694-001) | 1-866-250-2005 | 1-866-250-2005 |
| | EnvisionRxPlus Gold (S7694-035) | 1-866-250-2005 | 1-866-250-2005 |
| First Health Part D | First Health Premier (S5768-005) | 1-800-588-3322 | 1-866-865-0662 |
| | First Health Select (S5768-049) | 1-800-588-3322 | 1-866-865-0662 |
| FOX Insurance Company | Fox Rx Care Choice Plan (S5557-002) | 1-888-369-7979 | 1-888-369-7979 |
| | Fox Rx Care Comprehensive Plan (S5557-007) | 1-888-369-7979 | 1-888-369-7979 |
| Health Net | Health Net Orange Option 1 (S5678-014) | 1-800-606-3604 | 1-800-806-8811 |
| | Health Net Orange Option 2 (S5678-013) | 1-800-606-3604 | 1-800-806-8811 |
| | Health Net Orange Option 3 (S5678-075) | 1-800-606-3604 | 1-800-806-8811 |
| HealthSpring Prescription Drug Plan | HealthSpring Prescription Drug Plan -Reg 1 (S5932-002) | 1-800-618-3694 | 1-866-845-6941 |
| Humana Insurance Company | Humana PDP Standard (S5884-092) | 1-800-706-0872 | 1-800-281-6918 |
| | Humana PDP Enhanced (S5884-095) | 1-800-706-0872 | 1-800-281-6918 |
| | Humana PDP Complete (S5884-098) | 1-800-706-0872 | 1-800-281-6918 |
| Medco YOURx PLAN | Medco YOURx PLAN (S5660-001) | 1-800-758-3605 | 1-800-758-4574 |
| MEMBERHEALTH | Community Care Rx BASIC (S5803-070) | 1-866-684-5353 | 1-866-684-5353 |
| | Community Care Rx CHOICE (S5803-138) | 1-866-684-5353 | 1-866-684-5353 |
| | Community Care Rx GOLD (S5803-218) | 1-866-684-5353 | 1-866-684-5353 |
| NMHC Group Solutions | NMHC Medicare PDP Gold (S8841-001) | 1-866-443-1095 | 1-866-443-1095 |

| Company | Plan (and ID Numbers) | Enrollment Phone Number | Member Services Phone Number |
|---|---|---|---|
| Pennsylvania Life Insurance Company | Prescription Pathway Gold Plan Reg 1 (S5597-034) | 1-800-978-9500 | 1-866-566-3050 |
| | Prescription Pathway Bronze Plan Reg 1 (S5597-067) | 1-800-978-9500 | 1-866-566-3050 |
| | Prescription Pathway Platinum Plan Reg 1 (S5597-199) | 1-800-978-9500 | 1-866-566-3050 |
| RxAmerica | Advantage Star Plan (S5644-067) | 1-877-279-0370 | 1-800-429-6686 |
| | Advantage Freedom Plan (S5644-045) | 1-877-279-0373 | 1-800-429-6686 |
| SAMAscript | SAMAScript (S7950-001) | 1-800-605-9208 | 1-800-605-9208 |
| SilverScript | SilverScript (S5601-002) | 1-866-552-6106 | 1-866-235-5660 |
| | SilverScript Plus (S5601-003) | 1-866-552-6106 | 1-866-235-5660 |
| | SilverScript Complete (S5601-072) | 1-866-552-6106 | 1-866-235-5660 |
| Sterling Prescription Drug Plan | Sterling Rx (S4802-022) | 1-888-909-1713 | 1-866-865-0664 |
| | Sterling Rx Plus (S4802-034) | 1-888-909-1713 | 1-866-865-0664 |
| Unicare | MedicareRx Rewards Value (S5960-001) | 1-888-949-5384 | 1-800-928-6201 |
| | MedicareRx Rewards Premier (S5960-071) | 1-888-949-5384 | 1-800-928-6201 |
| United American Insurance Company | UA Medicare Part D Rx Covg - Silver Plan (S5755-040) | 1-866-446-0100 | 1-866-299-3406 |
| | UA Medicare Part D Prescription Drug Cov (S5755-005) | 1-866-446-0100 | 1-866-524-4169 |
| UnitedHealthcare | AARP MedicareRx Plan - Saver (S5921-171) | 1-800-745-0922 | 1-888-867-5575 |
| | AARP MedicareRx Plan (S5820-001) | 1-888-867-5564 | 1-888-867-5575 |
| | UnitedHealth Rx Basic (S5921-172) | 1-888-867-5561 | 1-888-867-5562 |
| | UnitedHealth Rx Extended (S5820-105) | 1-888-867-5561 | 1-888-867-5562 |
| | AARP MedicareRx Plan - Enhanced (S5921-173) | 1-888-867-5564 | 1-888-867-5575 |
| WellCare | WellCare Classic (S5967-138) | 1-888-423-5252 | 1-888-550-5252 |
| | WellCare Signature (S5967-035) | 1-888-423-5252 | 1-888-550-5252 |
| | WellCare Complete (S5967-069) | 1-888-423-5252 | 1-888-550-5252 |

**Additional Contacts:**

| | |
|---|---|
| CMS - Medicare | 1-800-MEDICARE (1-800-633-4227) |
| SSA - Social Security | 1-800-772-1213 |
| NH - ServiceLink | 1-866-634-9412 |
| CMS - Boston RO | 1-617-565-1232 |

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and State Operations**

March 17, 2006

**SMD 06-004**

Dear State Medicaid Director:

As you are aware, with the transfer of responsibility for outpatient drugs for dual eligible Medicare and Medicaid beneficiaries from States to Medicare Part D, Medicaid programs no longer must pay for high-cost home infusion drugs. With the new drug benefit in effect, Part D now covers those drugs. It is critical, however, that States and the Medicare Part D program work together to assure that home infusion services are efficiently and effectively provided.

Questions have been raised about the coverage of drugs, medical supplies, and other services for dual eligible Medicare and Medicaid beneficiaries that are commonly provided as a service package. In particular, we are aware of some confusion concerning the payment for home infusion services that may affect beneficiaries' access to proper and timely services. This letter clarifies the roles of the Medicare Part D drug program and the State Medicaid programs in providing these services. Because of the separate coverage responsibilities for components of this service, providers may be required to bill both the Medicare drug plan and the State Medicaid agency in order to receive payment. The Centers for Medicare & Medicaid Services (CMS) sent a similar letter to Medicare Part D drug plans so as to clarify their responsibilities for home infusion drugs. (See the letter at http://www.cms.hhs.gov/PrescriptionDrugCovContra/HPMSGH/list.asp#TopOfPage on the CMS Web site.)

Medicare Part D requires coverage of home infusion drugs that are not currently covered under Parts A and B of Medicare. Although the Medicare Part D benefit does not cover equipment, supplies, and professional services associated with home infusion therapy, it does cover the ingredient costs and dispensing fees associated with infused covered Part D drugs.

In addition, the Part D plan's contracted pharmacy is expected to deliver home infused drugs in a form that can be administered in a clinically appropriate fashion. Home infusion networks must have contracted pharmacies capable of providing infusible Part D drugs for both short-term acute care (e.g., IV antibiotics) and long-term chronic care (e.g., alpha$^1$ protease inhibitor). While the same network pharmacy does not necessarily need to be capable of providing the full range of home infusion Part D drugs, the home infusion network, in aggregate, must have a sufficient number of pharmacies capable of providing the full range of home infusion Part D drugs to ensure that enrollees have adequate access to medically necessary home infusion therapies.

Generally, facility discharge planners, in collaboration with a patient's physician, are responsible for ensuring that the components needed to safely administer a drug at home are present upon a patient's discharge. However, the Part D plan's in-network contracted pharmacy vendor—particularly a vendor that does not supply the necessary ancillary services (which are not Medicare Part D benefits)—must seek assurances that another entity, such as a home health agency, can arrange for the provision of these services. In other words, Part D plans must require their contracted network pharmacies that deliver home infusion drugs to ensure that the professional services and ancillary supplies are in place before dispensing home infusion drugs. This action of obtaining assurances is a minimum quality assurance requirement on Part D plans under the Federal regulations at 42 CFR 423.153(c).

Except as provided below (in connection with bundled services), Medicaid Federal financial participation (FFP) is not available when the home infusion drugs are covered under Part D. Medicaid FFP, likewise, is not available for the dispensing fee associated with the provision of these drugs, as the Part D payment includes this fee. Medicaid FFP is available for medical supplies and services associated with administering the infused drugs. Section 1902(a)(10)(B) of the Act requires that the coverage afforded to each categorically needy individual eligible under the State plan be equal in amount, duration, and scope to the coverage afforded to all other categorically needy individuals. In addition, coverage afforded to categorically needy eligibles must be no less in amount, duration, and scope than that provided to medically needy individuals covered under the State plan. Therefore, to the extent to which Medicaid covers these supplies and services for its non-dual eligible Medicaid population, the State must also cover these for full benefit dual eligibles.

States also have the option to bundle Medicaid payment for home infusion and pay a single fee to cover the drug, supplies, and services associated with this treatment. In this case, the entire payment is eligible for FFP. This does not violate the requirement that Medicare be the primary payer for Part D covered drugs (at 42 CFR 423.906(b)), because the payment is for the bundled service and not specifically for the drug.

Please inform your Medicaid provider community of these split billing and coverage requirements so that Medicaid can work with Part D to assure access to home infusion drugs and services. Also, please make sure that your Medicaid Management Information System can process this type of split billing.

If you have any questions regarding these Medicare provisions, please contact Ms. Alissa Deboy at (410) 786-6041 or for the Medicaid provisions, please contact Ms. Deirdre Duzor of my staff at (410) 786-4626.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
For Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Senior Director, Access Policy
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Senior Health Policy Analyst
Council of State Governments

# How to report and resolve Medicare Part D complaints and problems

The Centers for Medicare & Medicaid Services (CMS) have set forth procedures for a Complaint Tracking System in order to best ensure a problem or grievance concerning a Medicare Part D plan is resolved.

The main purpose of this information is to expedite problems and complaints, to track problems and complaints on a national level, and to ensure Drug Plans follow the rules set forth by CMS and the Medicare Modernization Act.

To report a complaint or situation that involves problems with Part D processing, contact the Drug plan. Note: it's a good idea, to first ask the beneficiary, or their representative if he or she has already contacted the Drug Plan or 1-800-MEDICARE. If he or she has, the complaint is already being tracked and is under review.

CMS recommends the following process if the beneficiary has not yet made a complaint, or if he or she has made a complaint and a reasonable amount of time has passed without resolution, or if the beneficiary has a dire or urgent need:

**Step 1**: Contact the Medicare beneficiary's Drug Plan. Have at least 5 points of identification available, (i.e., name, address, plan member ID (if known), DOB, Medicare HIC#, Low Income Subsidy (Medicaid, Medicare Savings Programs, or other LIS through SSA), and telephone number.

Problems should be resolved based on the urgency, i.e. the beneficiary's health condition. For instance, if the issue involves a coverage determination or redetermination and the beneficiary has not yet purchased or received their medication, the plan must respond to the complaint within 24 hours. The Medicare drug plan should also be able to state when the beneficiary or his or her authorized representative can expect a resolution.

**Step 2**. If the complaint is not resolved satisfactorily or in a timely manner, call 1-800-MEDICARE (633-4227).

Complaints will be logged into CMS's Complaint Tracking Module (CTM) and transmitted directly to the Drug Plan with specific guidelines and timeframe for closing the complaint.

**Step 3**. If Steps 1 & 2 do not resolve the problem, follow-up with the Boston Regional Office at **1-617-565-1232**, or by email to CMSPartDComplaints_RO1@cms.hhs.gov.

To avoid duplicate complaints, do not call 1-800-Medicare again. Medicare's customer services representatives cannot access or provide status to the initial complaint.

During resolution, the Drug Plan or CMS will not contact you if you are making a complaint on behalf of a beneficiary unless you are the authorized representative. However, if no other telephone number is available, you could be contacted.